COMMUNITY CATALYST

September 15, 2016

The Honorable Sylvia Mathews Burwell, Secretary
U.S. Department of Health and Human Services
200 Independence Avenue SW
Washington, DC 20201

Dear Secretary Burwell,

Community Catalyst respectfully submits the following comments to the Centers for Medicare & Medicaid Services (CMS) and the Department of Health and Human Services (HHS) in response to the state of New Hampshire's requested amendment to the Section 1115(a) Medicaid Research and Demonstration Waiver entitled "New Hampshire Health Protection Program (NHPP) Premium Assistance."

Community Catalyst is a national non-profit advocacy organization dedicated to quality affordable health care for all. Since 1997, Community Catalyst has been working to build the consumer and community leadership required to transform the American health system. With the belief that this transformation will happen when consumers are fully engaged and have an organized voice, Community Catalyst works in partnership with national, state and local consumer organizations, policymakers, and foundations, providing leadership and support to change the health care system so it serves everyone - especially vulnerable members of society.

We applaud the state of New Hampshire for reauthorizing Medicaid expansion on April 5, 2016 so that NHPP would go through December 31, 2018. However, we urge that no amendments to the state's waiver demonstration be approved if the waiver would make it harder for the expansion population of non-disabled adults to enroll in and maintain coverage. Essentially, CMS should reject further requests that would leave Medicaid expansion beneficiaries worse off than they are in the absence of the requested changes.

The following are our specific comments on the components of the waiver amendment proposal:

**Work requirements do not promote the Medicaid program's objectives of helping people access and maintain health coverage.** New Hampshire proposes to add an employment and work training requirement of 30 hours a week. We recommend rejecting this proposal because it does not further the purposes of the Medicaid Act.

CMS has rejected prior work requirement proposals from other states because the purpose of Medicaid is to provide health coverage to people who cannot afford it. Linking Medicaid eligibility to employment has no connection to the purposes of the Medicaid program and is thus outside the scope of the Secretary's authority under section 1115 of the Social Security Act. There is also evidence that work requirements do not result in long term employment and may

instead simply mean the loss of health insurance coverage.[1] Finally, states can make referrals to job search or other work supports that are not a condition of eligibility without a waiver.

**Requiring proof of citizenship and New Hampshire residency creates barriers to enrolling in Medicaid for eligible individuals.** The state proposes requiring newly eligible adults to provide two forms of identification to verify United States citizenship and either a driver's license or photo identification card to prove New Hampshire residency. We recommend rejecting this proposal because it creates barriers to enrolling in coverage for eligible adults. Additionally, New Hampshire's citizenship documentation proposal could be read to bar eligibility for otherwise eligible legal immigrants, which is impermissible under the Medicaid statute.

Research has shown that implementation of a requirement to provide documentation proving citizenship impedes access to coverage. In fact, data from New Hampshire revealed the percentage of applications closed due to missing documents increased significantly from around 10 percent of applications in 2005 to 20 percent in 2006 after implementation of the federal requirement then in effect.[2]

To address these problems, states have the option to utilize electronic data matching with the Social Security Administration database to confirm an applicant's claim of citizenship. Since citizenship can be easily verified using electronic methods there is no need for individuals to provide documentation. We recommend rejecting New Hampshire's proposal as it seems designed to create barriers to enrollment for eligible individuals.

**Added cost-sharing for Medicaid beneficiaries reduces access to needed services and does not decrease non-emergent use of the emergency department.**

New Hampshire proposes adding a charge for non-emergency use of the emergency department (ED) of $8 in the first instance, and $25 for each subsequent visit. We recommend rejecting this proposal because charging co-pays to low-income adults on Medicaid is an unnecessary financial burden and a barrier to coverage and accessing needed health services.

According to HHS' Office of the Assistant Secretary for Planning and Evaluation, even minimal cost-sharing results in lower access to needed services.[3] Requiring Medicaid beneficiaries to meet these additional costs runs counter to the purposes of the Medicaid program to facilitate access to needed health services. This policy proposal will likely result in Medicaid beneficiaries forgoing care and potentially compromising their health.

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[1] LaDonna Pavetti, "Work Requirements Don't Cut Poverty, Evidence Shows," Center on Budget and Policy Priorities, updated June 7, 2016, http://www.cbpp.org/research/poverty-and-inequality/work-requirements-dont-cut-poverty-evidence-shows.

[2] Donna Cohen Ross, "New Medicaid Citizenship Documentation Requirement Is Taking a Toll: States Report Enrollment is Down and Administrative Costs Are Up," Center on Budget and Policy Priorities, revised March 13, 2007, http://www.cbpp.org/research/new-medicaid-citizenship-documentation-requirement-is-taking-a-toll-states-report.

[3] Office of the Assistant Secretary for Planning and Evaluation, "Financial Condition and Health Care Burdens Of People In Deep Poverty" July 16, 2015, https://aspe.hhs.gov/sites/default/files/pdf/108461/ib_DeepPoor.pdf.

Charging copayments to Medicaid beneficiaries is especially ineffective in the case of visits to the ED. Studies show that non-urgent ED utilization is only 10 percent of Medicaid ED visits, which is on par with private insurance.[4] This finding is supported by the state's commissioned report that non-emergent ED use by Medicaid enrollees in New Hampshire is estimated to be 5 percent of all emergency visits. Further, a multi-state study that revealed that copays only reduced the rate of emergency room visits by Medicaid recipients by less than one-tenth of 1 percent.[5]

A provision like this only puts a burden on Medicaid beneficiaries without targeting the root causes of non-emergent ED use or achieving savings to the health care system. Systemic approaches to reducing ED efficiencies are more effective at tackling true drivers of ED utilization. States such as Georgia and New Mexico have found ways to lower ED use by expanding access to primary care services and targeting populations more likely to visit the emergency room without charging excessive co-pays.[6] If New Hampshire is truly concerned about inappropriate emergency room usage, it can adopt one of these models.

Finally, a charge for non-emergency use of the ED is already being tested in Indiana under its expansion waiver, so there is no reason to grant another state a similar waiver until the evidence from Indiana is collected and more is known about the extent to which higher co-pays deter ED use.

Thank you for your willingness to consider our comments.

Respectfully submitted,

Robert Restuccia
Executive Director
Community Catalyst

[4] *See* Garcia et al. 2010. Emergency Department Visitors and Visits: Who Used the Emergency Room in 2007? CDC, NCHS Data Brief No 38 and Sommers et al. 2012. Dispelling Myths About Emergency Department Use: Majority of Medicaid Visits Are for Urgent or More Serious Symptoms. Center for Studying Health Systems Change.

[5] Siddiqui, M., Roberts, E., Pollack, C. (2015). The Effect of Emergency Department Copayments for Medicaid Beneficiaries Following the Deficit Reduction Act of 2005. JAMA. Retrieved from http://archinte.jamanetwork.com/article.aspx?articleid=2091743

[6] Jessica Schubel and Judith Solomon, "States Can Improve Health Outcomes and Lower Costs in Medicaid Using Existing Flexibility," Center on Budget and Policy Priorities, April 9, 2015, available at http://www.cbpp.org/research/health/states-can-improve-health-outcomes-and-lower-costs-in-medicaid-using-existing.